

SPANISH VERSION

WOMEN'S INTERAGENCY HIV STUDY
PHYSICAL EXAMINATION
FORM 07

AFFIX ID LABEL HERE →

PARTICIPANT ID: - - -

WIHS STUDY VISIT #:

FORM VERSION: **10/01/04**

EXAMINER'S INITIALS:

DATE OF PHYSICAL EXAM: / /
M D Y

PARTICIPANT'S DATE OF BIRTH:
(VERIFY WITH PARTICIPANT) / /
M D Y

TIME MODULE BEGAN: : AM.....1
PM.....2

TIME MODULE ENDED: : AM.....1
PM.....2

SECTION A. GENERAL PHYSICAL CHARACTERISTICS AND BODY HABITUS

A1. a. WEIGHT LBS
b. EVEN-NUMBERED VISIT?
YES1
NO.....2 (A3b)

c. HEIGHT IN

A3. b. IS PARTICIPANT PREGNANT?
YES1 (SECTION B)
NO.....2

A5. VISUAL ASSESSMENT

BODY PART:	(NOTE: IF NOT NORMAL, INDICATE SEVERITY IN NEXT COLUMN.)			SEVERITY*		
	NORMAL	FAT	WASTED	MILD	MODERATE	SEVERE
a) Her chest is...	1 (b)	2	3	1	2	3
b) Her abdomen is ...	1 (c)	2	3	1	2	3
c) Her waist is...	1 (d)	2	3	1	2	3
d) Her face is...	1 (e)	2	3	1	2	3
e) Her cheeks, just lateral to the nose and mouth are...	1 (f)	2	3	1	2	3
f) Her upper back is...	1 (g)	2	3	1	2	3
g) Her neck is...	1 (h)	2	3	1	2	3
h) Her arms are...	1 (i)	2	3	1	2	3
i) Her legs are...	1 (j)	2	3	1	2	3
j) Her buttocks are...	1 (A6)	2	3	1	2	3

***MILD** – Only seen if looked for.

MODERATE – Easily seen.

SEVERE – Obvious immediately.

A6. CLINICAL IMPRESSION OF LIPODYSTROPHY

a. DOES PARTICIPANT EXHIBIT ANY SIGNS OF LIPOATROPHY (PERIPHERAL FAT LOSS)?

YES1
NO.....2

b. DOES PARTICIPANT EXHIBIT ANY SIGNS OF LIPOHYPERTROPHY (CENTRAL FAT ACCUMULATION)?

YES1
NO.....2

PROMPT:

- IF PARTICIPANT IS POST-PARTUM AND NOT BREASTFEEDING, DO NOT DO BODY MEASURES, SKINFOLDS OR BIA UNTIL PARTICIPANT IS ONE YEAR POST-DELIVERY.
- IF PARTICIPANT IS POST-PARTUM AND BREASTFEEDING, DO NOT DO BODY MEASURES, SKINFOLDS OR BIA UNTIL PARTICIPANT IS SIX MONTHS POST-DELIVERY. DO NOT DO CHEST GIRTH MEASUREMENTS UNTIL PARTICIPANT IS ONE YEAR POST-DELIVERY.

PLEASE RECORD A RESPONSE OF “-1” FOR THESE QUESTIONS AND RECORD REASON IN QUESTION 25 (COMMENTS FIELD).

WIHSID:

BODY MEASURES (GIRTH in CM):

	MEASURE #1	MEASURE #2	a. DOES DIFFERENCE BETWEEN #1 AND #2 EXCEED 0.7 CM?		MEASURE #3
			YES	NO	
A7. UPPER ARM	_ _ _ . _ CM	_ _ _ . _ CM	1	2 (A8)	_ _ _ . _ CM
A8. CHEST	_ _ _ . _ CM	_ _ _ . _ CM	1	2 (A9)	_ _ _ . _ CM
A9. WAIST	_ _ _ . _ CM	_ _ _ . _ CM	1	2 (A10)	_ _ _ . _ CM
A10. HIP	_ _ _ . _ CM	_ _ _ . _ CM	1	2 (A11)	_ _ _ . _ CM
A11. THIGH	_ _ _ . _ CM	_ _ _ . _ CM	1	2 (A12)	_ _ _ . _ CM

A12. DORSOCERVICAL FAT PAD

a. PRESENT1
 ABSENT2 (A13)

b. SEVERITY

MILD1
 MODERATE2
 SEVERE3

A13. INITIALS OF CLINICIAN WHO PERFORMED BODY MEASURES: ___ ___ ___

SKINFOLDS (in MM):

	MEASURE #1	MEASURE #2	a. DOES DIFFERENCE BETWEEN #1 AND #2 EXCEED 2 MM?		MEASURE #3
			YES	NO	
A14. THIGH	_ _ . _ MM	_ _ . _ MM	1	2 (A15)	_ _ . _ MM
A15. TRICEPS	_ _ . _ MM	_ _ . _ MM	1	2 (A16)	_ _ . _ MM
A16. SUBSCAPULAR	_ _ . _ MM	_ _ . _ MM	1	2 (A17)	_ _ . _ MM
A17. SUPRAILIAC	_ _ . _ MM	_ _ . _ MM	1	2 (A18)	_ _ . _ MM

A18. INITIALS OF CLINICIAN PERFORMING SKINFOLD MEASURES: ___ ___ ___

BIA RESULTS:

A19. En las últimas 8 horas, ¿ha hecho usted suficiente ejercicio para sudar y tener que respirar fuerte?

YES1
 NO.....2

WIHSID:

A20. ¿Ha usted tomado más de 4 tazas de café, te, soda, agua u otras bebidas en las últimas dos horas?

YES1
NO.....2

A21. ¿Ha usted tomado más de 4 vasos de cerveza, vino u otro licor hoy?

YES1
NO.....2

PROMPT: TAKE TWO MEASURES. ENTER THE RESISTANCE (Rx) AND REACTANCE (Xc) FOR EACH ONE.

A22. Rx #1: ||| ohms Can't obtain

Xc #1: ||| ohms Can't obtain

A23. Rx #2: ||| ohms Can't obtain

Xc #2: ||| ohms Can't obtain

A24. INITIALS OF CLINICIAN PERFORMING BIA: _____

A25. COMMENTS: _____

SECTION B: SKIN EXAM

NOTE: AS YOU PROCEED WITH THE PHYSICAL EXAM, RESPONSES CIRCLED "YES" THAT ARE SHADED REQUIRE PROMPT REFERRAL FOR EVALUATION AND/OR TREATMENT. PLEASE REFER TO YOUR MANUAL FOR REFERRAL GUIDELINES.

B1a. Desde su visita en (MES) para el estudio, ¿algún profesional de salud le ha dicho que tenía una reacción alérgica (erupción) a una medicación que estaba tomando?

YES1
NO.....2

B1. SKIN EXAM:

NORMAL 1 (SECTION C)
ABNORMAL..... 2
NOT DONE 3 (SECTION C)

B2. TOTAL # OF DIFFERENT LOCATION CODES RECORDED AT B3 – B8. ||

NOTE: THE # OF BOXES COMPLETED (B3–B8) MUST EQUAL THE VALUE RECORDED AT B2.

NOTE: REFER PARTICIPANTS WITH SKIN LESIONS AS APPROPRIATE TO MEDICAL PROVIDER.

WIHSID:

START F07s1

LOCATION CODES			
12 Generalized	16 Posterior chest	66 Buttocks	77 Feet
15 Scalp	04 Axilla	03 Arms	05 Soles
01 Face	17 Anterior abdomen	18 Hands	11 Nails
06 Neck	07 Lower back	10 Palms	13 Other
02 Anterior chest	09 Inguina	08 Legs	14 3 or more locations

DIAGNOSIS CODES			
Bacterial: 245 Folliculitis	253 Tinea versicolor (pigment changing)	275 Eosinophilic folliculitis 276 Rosacea 278 Pruritis (not otherwise defined)	Viral: 257 Herpes simplex 252 Herpes zoster-varicella 247 Molluscum 254 Wart
Fungal: 259 Onychomycosis (nails) 202 Tinea capitis (scalp) 203 Tinea corporis (body) 250 Tinea cruris (groin) 263 Tinea pedis (feet)	Inflammatory: 241 Acne 206 Atopic dermatitis 243 Drug rash 261 Seborrheic dermatitis 248 Psoriasis 264 Xerosis (dry skin)	Neoplastic: 210 Basal cell carcinoma 258 Kaposi's sarcoma 211 Squamous cell carcinoma	Other: 213 Alopecia (other) 265 Other 299 Unknown

<p>B3. LOCATION #1</p> <p>a. LOCATION CODE <input type="text"/></p> <p>b. DIAGNOSIS (If unknown enter "299") <input type="text"/></p> <p>PROMPT: IF NO OTHER LOCATIONS SKIP TO SECTION C</p>	<p>B4. LOCATION #2</p> <p>a. LOCATION CODE <input type="text"/></p> <p>b. DIAGNOSIS (If unknown enter "299") <input type="text"/></p> <p>PROMPT: IF NO OTHER LOCATIONS SKIP TO SECTION C</p>
<p>B5. LOCATION #3</p> <p>a. LOCATION CODE <input type="text"/></p> <p>b. DIAGNOSIS (If unknown enter "299") <input type="text"/></p> <p>PROMPT: IF NO OTHER LOCATIONS SKIP TO SECTION C</p>	<p>B6. LOCATION #4</p> <p>a. LOCATION CODE <input type="text"/></p> <p>b. DIAGNOSIS (If unknown enter "299") <input type="text"/></p> <p>PROMPT: IF NO OTHER LOCATIONS SKIP TO SECTION C</p>
<p>B7. LOCATION #5</p> <p>a. LOCATION CODE <input type="text"/></p> <p>b. DIAGNOSIS (If unknown enter "299") <input type="text"/></p> <p>PROMPT: IF NO OTHER LOCATIONS SKIP TO SECTION C</p>	<p>B8. LOCATION #6</p> <p>a. LOCATION CODE <input type="text"/></p> <p>b. DIAGNOSIS (If unknown enter "299") <input type="text"/></p> <p>PROMPT: IF NO OTHER LOCATIONS SKIP TO SECTION C</p>

END F07s1

WIHSID:

SECTION C. ORAL EXAM

C1. ORAL EXAM

NORMAL 1 (SECTION D)
 ABNORMAL.....
 NOT DONE 3 (SECTION D)

C2. DOES THE PARTICIPANT EXHIBIT ANY SIGNS OF:

	<u>YES</u>	<u>NO</u>
a. ANGULAR CHELITIS?	1	2
b. PSEUDOMEMBRANOUS CANDIDIASIS?	1	2
c. ERYTHEMATOUS CANDIDIASIS?.....	1	2
d. HAIRY LEUKOPLAKIA?.....	1	2
e. ORAL PAPILLOMA/WART?.....	1	2
f. OTHER?	1	2 (SECTION D)

SPECIFY: _____

SECTION D. PHYSICAL FINDINGS IN THE BREASTS

D1. a. EVEN-NUMBERED VISIT?

YES1
 NO.....2 (SECTION E)

b. BREAST EXAM

NORMAL 1 (SECTION E)
 ABNORMAL.....
 NOT DONE 3 (SECTION E)

FINDINGS:	a. RIGHT		b. LEFT	
	YES	NO	YES	NO
D2. nipple discharge	1	2	1	2
D3. Nodularity (fibrocystic changes)	1	2	1	2
D4. retraction, other skin	1	2	1	2
D5. Mastectomy/lumpectomy for cancer	1	2	1	2
D6. evidence of prior breast biopsy	1	2	1	2
D7. Other	1	2	1	2
	_____ (SPECIFY)		_____ (SPECIFY)	

D8. BREAST MASS(ES) PRESENT?

YES
 NO..... 2 (SECTION E)

NOTE: IF NEW ONSET (APPEARING SINCE LAST EXAM AND/OR UNEVALUATED) BREAST MASSES OR OTHER ABNORMALITIES, REFER AS APPROPRIATE TO PARTICIPANT’S MEDICAL PROVIDER.

LOCATION	RIGHT MASS		a. SIZE	b. OLD MASS	
	YES	NO		YES	NO
D9. Medial upper	1	2 (D10)	_ _ . _ cm	1	2
D10. Lateral upper	1	2 (D11)	_ _ . _ cm	1	2
D11. Medial lower	1	2 (D12)	_ _ . _ cm	1	2
D12. Lateral lower	1	2 (D13)	_ _ . _ cm	1	2
D13. Areola/ periareola	1	2 (D14)	_ _ . _ cm	1	2

LOCATION	LEFT MASS		a. SIZE	b. OLD MASS	
	YES	NO		YES	NO
D14. Medial upper	1	2 (D15)	_ _ . _ cm	1	2
D15. Lateral upper	1	2 (D16)	_ _ . _ cm	1	2
D16. Medial lower	1	2 (D17)	_ _ . _ cm	1	2
D17. Lateral lower	1	2 (D18)	_ _ . _ cm	1	2
D18. Areola/ periareola	1	2 (E1)	_ _ . _ cm	1	2

SECTION E. BLOOD PRESSURE MEASUREMENT

E1. MEASURE AND RECORD THREE TIMES USING DINAMAP MONITOR

MEASUREMENT	a. SYSTOLIC	b. DIASTOLIC	c. PULSE
1 ST	_ _ _	_ _ _	_ _ _
2 ND	_ _ _	_ _ _	_ _ _
3 RD	_ _ _	_ _ _	_ _ _

PROMPT: IF BLOOD PRESSURE < 90/60 OR > 140/90, REFER TO PARTICIPANT’S MEDICAL PROVIDER.

PROMPT: COMPLETE “TIME MODULE ENDED” ON PAGE 1. THEN PROCEED TO FORM 08.

PLEASE NOTE: ANY ADDITIONAL COMMENTS SHOULD BE WRITTEN IN THE SPACE PROVIDED BELOW.

ADDITIONAL COMMENTS: _____

